

PEDIATRIC NEWS

San Antonio Military Pediatric Center



Wilford Hall Air Force Medical Center
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www.sampc.amedd.army.mil



April 2003

Volume 10 Number 2

Housestaff Puzzler

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A 5-year-old white female presents to the pediatric clinic with a chief complaint of persistent fever. She was in her usual state of excellent health until 1 week prior to presentation when she was originally seen in clinic for a 4-day history of fever and sore throat. She was diagnosed with GABHS pharyngitis after a positive throat culture and was started on Penicillin VK. She returned to clinic after 3 days on penicillin for persistent fever and was noted to have a newly appreciated murmur.

The patient's father denies noting any apparent chest pain, palpitations, near syncope or syncope. He reports that her exercise tolerance is similar to that of her peers. A rash was present at the beginning of her illness but it has since resolved. She denies joint swelling or pain. She denies any abnormal movements. She also denies headache, epistaxis, abdominal pain, nausea, vomiting, diarrhea, back pain, or dysuria.

Past medical history is non-contributory, including no prior history of recurrent

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The Ins and Outs of Blood Product Donation Part I

(Part II - June 2003)
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A major goal of transfusion medicine practice in the last decade has been to reduce the risk of transfusion-transmitted infection to as low a level as possible. The most recent estimates of the per unit risk of transfusion-acquired viral disease in the United States are as follows: one in 65,000 for hepatitis B, one in 103,000 for hepatitis C, one in 493,000 for HIV (and probably lower: one in 677,000 since the introduction of HIV antigen testing), and one in 641,000 for HTLV. The risks for hepatitis C and HIV should now be even lower, following the implementation in 1999-2000 of nucleic acid testing on pooled plasma samples for each of these viruses. These risks are now estimated as less than one in 2-3 million for both agents.

The major procedure for screening donors at the donation site is the medical history interview, which contains questions to protect the recipient from acquiring a transfusion transmitted infection and to protect the donor from suffering an adverse reaction after donation. In 1983, with the recognition of the possible transmission of HIV by transfusion, the health history interview assumed new importance and became more complex and probing than it had previously been. The trend of adding medically sophisticated questions and/or socially sensitive behavioral questions to the donor interview has continued to the present day. Donors are asked questions concerning their sexual activities, their injection drug use

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Promotion of Successful Breastfeeding

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Breastfeeding rates have become a public health focus. An increasing body of evidence shows the many benefits of breastfeeding. Infants who are breastfed suffer fewer infectious diseases of all etiologies, are less like to die from SIDS or to suffer from allergies and asthma. They are less likely to have speech problems also. The benefits of

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pharyngitis. She has not been hospitalized or had significant illnesses. Family history is also non-contributory, including no history of sudden death, valvular cardiac disease or arrhythmia.

She is non-toxic appearing, afebrile and has normal vital signs. Physical exam is normal except for her cardiovascular exam. You note a mildly hyperdynamic precordium. Upon auscultation you appreciate a RRR with a normal S1 and minimally split S2. You also hear a grade IV/VI harsh, high-pitched SEM @ apex in band-like distribution, a grade III/VI harsh SEM @ LUSB radiating to lung fields, and a grade II/IV mid-diastolic rumble at apex. Her abdomen is normal without hepatosplenomegaly. Her extremities are warm without cyanosis, clubbing, or edema. Her pulses are 1+ in all extremities without brachial-femoral delay. You obtain a 12-lead EKG that shows normal sinus rhythm with normal intervals and voltages. You obtain the following labs: ASO = 1250 Todd units (+ if > 100 at her age), DNASE B Ab = 1:960, CRP = 0.7, ESR = 43, WBC = 5.9, H/H = 10.6/32.1, Platelets = 337,000, Throat culture = negative. You then consult Pediatric Cardiology.

Your exam is confirmed and an echocardiogram is performed. It reveals moderate to severe mitral insufficiency with no apparent aortic involvement. It also shows marked left atrial and left ventricular dilation with normal systolic function and a trivial pericardial effusion. The diagnosis of Acute Rheumatic Fever with active Rheumatic Carditis is made. The patient is given bedrest, and started on Lisinopril, ASA, Prednisone, and a monthly PCN prophylaxis regimen. She is followed and over six months her mitral insufficiency improves, her ESR/CRP

normalize and she is weaned off Prednisone and ASA. She continues on monthly PCN prophylaxis regimen.

A significant decline in the incidence of Acute Rheumatic Fever (ARF) has been noted in the United States for the past 50 years. It has, however, been persistently prevalent among lower income groups and recent outbreaks have been seen among middle class families in affluent suburban areas. ARF usually occurs in individuals between 5 and 18 years of age. All races and both sexes are equally affected.

The etiopathogenesis is thought to be associated with antigenic structures on the cell wall of Group A Strep. GAS cell wall antigens have been shown to have cross-reactivity with certain components of human tissues (heart and brain). Genetics is also an important factor as shown by familial cases and the fact that during epidemics of GAS tonsillopharyngitis only 3% develop ARF.

After a silent period following an upper airway infection with GAS (especially tonsillopharyngitis), patients develop a sudden onset of constitutional symptoms (fever, malaise, etc.). Arthritis, carditis, chorea, erythema marginatum, and subcutaneous nodules are the classic major manifestations of the Jones criteria. Other symptoms include arthralgias, epistaxis, serositis, and involvement of the lungs, kidneys and CNS.

Arthritis, present in about 80% of patients, is the most common feature. It is usually painful, migratory, of short duration, and affects the larger joints (knees, ankles, elbows, wrists, and shoulders).

Carditis is the most serious manifestation of ARF and affects 41%-83% of patients. Any cardiac layer can be affected but valvular lesions are most common. Common

clinical signs include tachycardia, murmurs, cardiomegaly, rhythm disturbances, friction rubs, and cardiac failure (rare). Mitral and aortic insufficiency are the most common events caused by rheumatic valvulitis.

Sydenham's chorea is an extrapyramidal disorder of fast, clonic, involuntary movements (usually face and limbs), hypotonia, and emotional lability. The first signs are usually difficulty in writing, talking, or walking. It most often occurs a few months after a GAS upper airway infection and is often the only manifestation of ARF. It has been reported in up to 30% of patients. Most cases are benign and resolve within 2-3 months, however cases have been reported that do not show improvement despite adequate therapy.

Subcutaneous nodules are usually 0.5 to 2 centimeters long, firm, and nontender. They are most commonly palpated on the extensor surfaces of joints (knees, elbows, and wrists). They last for only a few days and are found in 9% to 20% of patients. They are often associated with carditis.

Erythema marginatum is a rash with a pale center and a reddish-pink, irregular shaped border. It is usually nonpruritic and lasts a few days. It is highly specific for ARF but is only seen in 7% to 10% of patients. It is also often associated with a coexisting carditis.

The Jones criteria were created about 50 years ago secondary to concern for overdiagnosis of ARF. These criteria have been revised 4 times since, most recently in 1992. According to the Jones criteria, the probability of ARF is high when evidence of a GAS upper airway infection is found together with (1) two major manifestations (arthritis, carditis, chorea, erythema marginatum, and subcutaneous nodules) or (2) one major and two minor manifestations (fever, arthralgia, increased CRP or ESR, pro-

longed PR interval).

Acute rheumatic fever is diagnosed by clinical criteria. However, laboratory tests and ancillary studies may be helpful in the diagnosis. A CBC is typically not much help. With many inflammatory processes you may see a normochromic/normocytic anemia, but significant anemia is seen in less than 10% of patients. Leukocytosis and thrombocytosis may be seen. The best tests to measure acute phase response are CRP and ESR. Test for antistreptococcal antibodies are useful in detecting preceding infections with GAS. The ASO is most commonly available (look up age-specific reference values). AntiDNAase B is the last antibody to return to normal values and is the standard test to show preceding GAS infection in isolated Sydenham's chorea.

A CXR may show an enlarged heart and other evidence of cardiac disease. A prolonged PR interval is the most common finding on EKG and is present in around 30% of patients. A prolonged QT interval may be seen with myocarditis and if pericarditis is present you may see low-voltage QRS complexes and ST segment changes. There is some controversy over the role of echocardiography in the diagnosis of ARF. In a recent comparative study of patients with and without carditis, echo was not more sensitive than clinical examination at detecting valvulitis. Currently echocardiographic signs of valvulitis without auscultatory findings are insufficient as criteria for carditis.

The first step in the treatment of ARF is to eradicate GAS to avoid chronic and repetitive exposure of antigenic GAS components to the patient's immune system. In theory, any antibiotic to which streptococci are sensitive may be used. In practical terms however, best results are achieved with a single IM dose of benzathine penicillin G. This eliminates other variables that may

contribute to eradication failure including poor compliance and complicated dosing schedules. The recommended dose of penicillin G benzathine is 600,000 U for patients under 27 kg and 1,200,000 U for patients above 27 kg. For patients in whom PCN is contraindicated, once daily azithromycin (12mg/kg) for 5 days is an effective alternative.

The typical arthritis of ARF responds well to salicylates and NSAIDs. The same is not true for rheumatic carditis. Given its potential for morbidity, steroid therapy is necessary to treat carditis. Prednisone, 1 to 2 mg/kg/day (max 60mg/day), is usually sufficient. A prolonged course with gradual taper is recommended. Best rest is also extremely important and should be individually planned.

Sydenham's chorea associated with social and economic burdens should also be treated. Haloperidol at 0.5 to 1 mg/day has been used successfully. There is no proven benefit to steroid therapy in Sydenham's chorea.

The safest way to prevent recurrence of ARF in previously affected patients is with IM penicillin G benzathine. The Committee on ARF of the American Heart Association suggests doses of 600,000 IU (<27kg) to 1,200,000 IU (>27kg) every 4 weeks. Erythromycin, 250mg twice a day, is a good option for patients with PCN contraindications. Secondary prophylaxis should last for a minimum of 5 years after the last episode of ARF or until the patient reaches 21 years of age. If there is carditis any time during the follow-up, prophylaxis should be extended.

Acute rheumatic fever continues to be a major health problem in developing and developed countries. Sporadic outbreaks are occurring with increasing frequency. Despite some improvement in the developing world, ARF continues to be a frequently occurring inflammatory disease with often devastating cardiac sequelae and enormous

social and economic impact. Accurate diagnosis and treatment can eliminate or reduce the potential significant sequelae associated with ARF.

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history, their prior HIV testing history, and their history of selected sexually transmitted diseases. Donors are also queried concerning exposure to or medical history of hepatitis, malaria, CJD (Creutzfeldt-Jacob Disease), babesiosis, and Chagas' disease.

HUMAN IMMUNODEFICIENCY VIRUS

In April 1992, the FDA issued a set of recommendations for screening prospective donors for prevention of HIV transmission. These recommendations state that prospective donors:

- Must receive both oral and written information concerning HIV (AIDS) risk factors and the potential

for HIV transmission through donated blood. This information should include informing the donor that, in early HIV infection, a donor may be infectious and capable of transmitting HIV despite having a negative test for HIV antibody.

- Should be given specific information as to how they can obtain an HIV antibody test at a site other than the donor center.

- Should be told that all units of donated blood will be tested for HIV antibody and, if positive, the donor will be notified of the test result and his/her name will be placed on a donor deferral registry.

- Should be advised not to donate if symptoms which may be compatible with HIV infection are present. These symptoms include persistent fevers, night sweats, unexplained weight loss, persistent cough or shortness of breath, persistent diarrhea, swollen lymph nodes that persist for more than one month, presence of whitish oral lesions, or the presence of bluish purple spots on the skin or in the mouth.

- Should be asked direct health history questions about behaviors that put them at risk for HIV. Preferably these questions should be asked orally.

Donors must sign a consent form that specifically states that they understand that they should not donate blood if they are at risk for HIV infection. The specific information to be obtained from donors during the donor interview which will lead to a permanent deferral as a blood donor includes:

- Have you ever had clinical or laboratory evidence of AIDS or HIV infection?

- For men: Have you had sex with another man, even once since 1977?

- Have you ever injected intravenous drugs?

- Have you engaged in sex in

exchange for money or drugs since 1977?

- Have you received clotting factor concentrates for hemophilia or other clotting disorders?

The donor should also be asked questions regarding behaviors during the previous 12 month interval; a yes answer to any of these questions will lead to a temporary deferral which is removed 12 months after the last potential exposure. The donor should be asked if he/she has had sex in the past 12 months with:

- A person who has HIV infection or AIDS

- A prostitute

- A person who currently or previously used intravenous drugs?

- For women: a man who has had sex with another man (ie, a man who is bisexual)?

- A person receiving clotting factor concentrates?

The donor should also be asked if, in the past 12 months, he/she has had had syphilis or gonorrhea, received a blood transfusion, or experienced an accidental needlestick injury or a blood splash to a mucous membrane or nonintact skin. In 1995, the FDA recommended that individuals who are inmates of correctional institutions and individuals who have been incarcerated for more than 72 consecutive hours during the previous 12 months be deferred for 12 months from their last date of incarceration.

A preponderance of data has demonstrated that the theoretical possibility of long-term persistent HIV infection in the absence of detectable HIV antibody, HIV antigen, or clinical symptoms does not exist or is exceedingly rare. Multiple studies have demonstrated that HIV nucleic acid cannot be detected in HIV antibody-negative individuals from high risk groups who are at risk for latent HIV infection. Other data have shown that seroconversion for HIV is

highly likely to occur within six months of HIV exposure; in recent studies in health care workers exposed to HIV infected blood by needlestick injury, the longest interval from exposure to HIV seroconversion was 213 days.

Thus, HIV risk behaviors that can be defined as ending at a specific point in time (eg, sex with a particular person who demonstrated HIV risk behaviors, an accidental exposure to blood, a blood transfusion) should only defer a prospective donor for 12 months until serologic testing can definitively prove that the individual is free of HIV infection.

VIRAL HEPATITIS

Federal guidelines for preventing transfusion transmitted hepatitis were established decades ago. Hepatitis B is currently the viral infection that is most likely to occur after a blood transfusion (1:65,000). The current regulations require the following deferral policies:

- Persons with a history of viral hepatitis after age 10 are permanently deferred

- Persons currently or previously testing positive for HBsAg are permanently deferred

- Persons with a history of close contact with someone who has viral hepatitis are deferred for 12 months following their last potential exposure

- Persons who have received a blood transfusion are deferred for 12 months

A history of viral hepatitis applies only to clinical disease; deferral is not required when the donor's history is based solely on a positive serologic test result (ie, anti-HBc or anti-HBs) that indicates past exposure to HBV. The lack of deferral for viral hepatitis occurring before the age of 10 is based upon epidemiologic evidence in the United

States that clinical viral hepatitis occurring in early childhood is almost exclusively due to infection with the hepatitis A virus, which does not induce a chronic carrier state.

The definition of close contact with a person with viral hepatitis is somewhat problematic. One commonly used definition is sexual contact or the sharing of household, kitchen, or toilet facilities, as would occur with living in the same household. For hepatitis B virus (HBV), this definition appears reasonable since HBV can rarely be transmitted from an acutely infected patient to a household contact, probably through nonsexual contact with body fluids. Data do not support similar transmission for hepatitis C.

(Part II will appear in the June 03 issue of *Pediatric News*)



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breastfeeding are now being shown to continue on into adulthood. People who were breastfed as infants have a lower incidence of Crohn's disease, ulcerative colitis, diabetes, obesity, malocclusion, and dental caries. The Surgeon General's Healthy People 2010 target breastfeeding rates are 75% of babies in the early postpartum period, 50% at 6 months, and 25% at 1 year. The 2000 baseline rates are 68% in the early postpartum period, 31% at 6 months, and 18% at 1 year. As health care providers caring for children, it is imperative that we know how to support mothers who wish to breastfeed.

When the infant suckles at the nipple, nerve stimulation is transmitted to the pituitary gland. This stimulation causes release of the two primary hormones involved in

lactation. Prolactin from the anterior pituitary gland acts on the epithelial cells of the breast to cause milk production. Oxytocin is released from the posterior pituitary gland acts on the myoepithelial cells and causes milk ejection. As a provider you can support breastfeeding and help ensure success for the mother by educating her on basic physiology and normal feeding behaviors. Explain that the more the baby suckles at the breast, the more stimulation the pituitary gland receives, the more prolactin is produced, and therefore more milk is produced. Feeding on demand will maximize success with breastfeeding because the baby will nurse when he needs to and during growth spurts will naturally increase mother's milk supply. A mother should be educated about hunger cues and instructed to feed the baby when she sees these. Pacifier use has been directly linked to early weaning. All pacifier use is not evil. Anyone with a child can fully appreciate the sanity it can offer. Mothers need to be educated though that overuse of a pacifier - using it in place of feeding on demand - will eventually cause a decrease in her milk supply.

If the mother must return to work or school full time and wishes to continue to breastfeed her baby, she will have to introduce a bottle. Most lactation consultants will advise against artificial nipple use until the baby is at least four weeks old. This is NOT due to "nipple confusion" implying that infants are dumb and easily confused. Rather, they are smart. Milk comes out of a bottle much easier than from the breast. A baby will soon realize that if he cries long enough and refuses the breast, he will be able to feed much easier because he will be given a bottle eventually. If this pattern is continually enforced, the baby may not ever go back to effectively feeding at the breast. Though

mothers may pump in an attempt to maintain their milk supply, this may prove problematic for a couple reasons. First, many pumps sold on the market today that are affordable are not effective. These fall under commonly trusted baby product brand names. Some have even caused significant breast trauma. Second, even if the mother has a "good" pump, she may still suffer a supply problem because a pump is not as effective stimulation for the breast as the baby is. Infants' suckling causes both negative and positive pressure on the breast. Negative pressure from sucking and positive pressure from compression of the lactiferous sinuses. Even the best pump on the market only offers negative pressure. Additionally, pumps are not able to accurately mimic the suckling rhythm of a baby.

Some babies will refuse the bottle. When the mother must return to work or school full-time, this can evoke great anxiety for the parents. In these cases, recommend alternative feeding methods. Babies can be fed with a cup, syringe or spoon. This is usually not a difficult thing to accomplish. However most daycare centers will not comply with these feeding methods. The parents of such a baby will have to find a caregiver that is willing to feed the baby with an alternate method.

COMMON CAUSES OF BREAST PAIN

The most common reason women discontinue breastfeeding is due to discomfort. The most common reason for discomfort is a poor latch. You can do much to aid a nursing mother by employing some basic techniques. First, the baby should always be positioned with his ears, shoulders, and hip aligned. His abdomen should be facing his mother so that he can feed without turning his head. When the baby is latched onto the breast, the mother

must employ much patience to achieve a good latch on. She should tickle the baby's lip with her nipple and WAIT until the baby opens his mouth as if he is yawning. If this is not done correctly, the baby will latch to only the tip of the nipple. This will cause the tongue to abrade the nipple and will cause pain. When the baby opens his mouth very widely, the mother should quickly move the baby's mouth onto her breast. The goal is to get as much of the nipple and areola into the baby's mouth as possible. This will position the nipple far back in the baby's mouth and avoid abrasion with the tongue. When properly latched on, the baby's lower lip should be flanged outward. If it is tucked in, this too can cause nipple pain. If you see the baby latched on with his lower lip tucked in, you can usually bring it out by gently pulling downward on the chin.

Candidal infections can cause severe breast pain. Breastfeeding may be going well, without pain, and then the mother develops pain or itching on her breast(s), or notices oral thrush in her baby. Mother's nipples may look pink, red, have white plaques on them or may be entirely normal in appearance. The breast pain when a mother has a candidal infection is frequently described as stabbing, burning, or like "pokers" stabbing the breast. They may also report itching. When you see a child with oral thrush, you should ask if the mother is nursing. If so, you should ask mother if she has any of the above symptoms. Even if she does not have ANY symptoms, she has candida on her nipples and she **MUST** be treated concurrently with the baby if the infection is to clear up. Initial treatment for the baby may be nystatin oral suspension and for mother may be nystatin CREAM. Please do not prescribe nystatin solution for mother to apply to her breasts. When the sugar in the

suspension dries it adheres the nipple to whatever is in contact with it (breast pad, bra). This then causes nipple pain when the adherent object is removed. Mother's breasts may also be treated with clotrimazole cream. Regardless of which medication is chosen for mother, she should be advised to wash it off prior to nursing the infant. Nystatin oral solution should be applied to the baby's mouth QID. The antifungal cream should be applied to mother's nipples after every nursing. Both treatments should be continued for 2 weeks. Any object that is placed in the baby's mouth (pacifiers, teethingers, and bottle nipples) should be boiled for twenty minutes every day. Any object that mother leaks milk on should be washed in hot water. She should utilize her bath towel once then wash in hot water. Since candida lives in moist environments, it is often recommended that for the duration of therapy, paper towels be utilized in the bathroom instead of hand towels. Alternative treatment is with a single application of 0.5-1% gentian violet to the baby's mouth and the mother's nipples. The single application is often sufficient to eradicate the candida. If the symptoms do not resolve with single treatment, reapplication a few days later is indicated. For more severe infections (severe pain in mother's breasts, resistant candida, no improvement with topical therapy) fluconazole may be used in both baby and mother. Babies should receive 6mg/kg on day 1, then 3 mg/kg for the next 13 days. A single dose of 150mg fluconazole is NOT sufficient for mothers. They must be treated for 14 days. Initial loading dose may be 200 or 400 mg. The subsequent 13 doses should be ½ the loading dose (i.e. 200mg if loaded with 400mg or 100mg if loaded with 200mg).

MANAGEMENT OF THE YOUNG BREASTFED INFANT

As pediatric providers, we must be able to identify a breastfed baby who is not doing well. Two ways of doing this are by following the baby's stooling pattern and their weight gain.

Initially after birth, when a breastfed baby is only taking in colostrum, he will pass meconium stools. These will continue for roughly 3-5 days. Once mother's mature milk begins to come in, the baby's stool will become transitional. These stools are green and liquid. Following the transitional stools, a breastfed baby will begin to pass yellow, watery, seedy stools. At this point the baby should be having a **MINIMUM** of three stools per day. This pattern should continue until the baby is roughly six weeks old. Only after six weeks of life is it acceptable for exclusively breastfed babies to stool less than three times per day. If they are doing this prior to six weeks of life, it is a sign that milk transfer is ineffective or that there may be another pathologic condition.

Another indication that a breastfed baby is not being adequately nourished is the degree of weight loss he experiences after birth. If a baby has lost 8% or more of his birth weight by day of life three, he requires very close follow up until the weight loss is reversed. A child who loses 10% or more of his birth weight will need to be evaluated with electrolytes for hypernatremic dehydration. If a baby is continuing to lose weight after seven days of life, this is a sign that milk transfer is not optimal and a lactation consultant should be contacted.

SUPPORT BEYOND THE NEONATAL PERIOD

Follow up studies of the Baby

Friendly Hospital Initiative show an increase in breastfeeding duration when mothers are informed of breastfeeding resources. Simply giving information about a support group increases the duration mothers breastfeed.

BREASTFEEDING RESOURCES FOR MILITARY BENEFICIARIES IN SAN ANTONIO

Mom to Mom breastfeeding
support group
3rd floor BAMC, Health
Promotions Center
Every Friday
1300-1430
Walk in

Wilford Hall breastfeeding
support group
Last Thursday of every month
Location
Call WH clinic for appointment

The Lactation Center/ Meth
odist Healthcare System
575-0261
M-F 0830-1700
Sat 0900-1300
FREE lactation services

Mother's Milk First Lactation
Center
Baptist Health System
297-5096
Fee applies

La Leche League San Antonio
341-9669

Websites that may be useful
for breastfeeding mothers
are:

www.lalecheleague.org
www.breastfeeding.com
www.breastfeedingsupportservices.com

Tips for Parents Supporting the Child Whose Military Parent is Deploying

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1. Talk as a family before deployment: Before a deployment, military members are usually preoccupied with many preparatory activities at their military unit, requiring extended hours and increased workload. As a result, military members come home tired, perhaps late, and are already reluctant to address painful issues of impending separation. Family members frequently collude in this. It is important to overcome this resistance and make plans with the family as far ahead as possible.

2. Bestow, rather than "dump", responsibilities on remaining family members. Concerns expressed by children after a parent has been deployed are that everything has changed at home and they now have to do "everything" that the deployed parent used to do. Discussions before deployment, in which trust and faith in a child's ability to carry out a responsibility are expressed, are valuable times to help a child to feel he/she is important to the family, is important to the deployed parent, and that he/she can help share a potential burden with the remaining parent. As a result, the remaining parent will have more time and energy for the children.

3. Make plans for the family to continue to progress together, and include the deployed parent in ongoing projects. It is important that the family not put "life on hold" in anticipation of the return of the deployed parent. This will result in

stagnation, loss of direction, and burn-out. Make plans for specific goals to be reached by each of the children and the remaining parent, as well as family projects to work on. Help children design ways to communicate with the deployed parent, and relate progress made, so that the deployed parent can be part of that progress by seeing pictures, report cards, to which he/she can respond and provide encouragement. Make sure the remaining parent and deployed parent have specific plans on how to communicate. Keep regular but not too frequent communication. Keep the deployed parent informed and involved, but do not discuss problems and issues that he/she cannot do anything about.

4. Continue family traditions and develop new ones. One very stabilizing factor in a family is routine and tradition. Don't stop Friday pizza night, or Saturday outings because the parent has been deployed. If anything, become more predictable in continuing traditions. Family bowling night, attendance at and fellowship at places of worship, and involvement in events with other families are important ways to maintain a sense of stability and continuity. If the family has not previously had regular family traditions, now is a good time to start them. Encourage children to talk about these events and activities with the deployed parent in their communication.

5. Help children understand the finite nature of a deployment by devising developmentally appropriate time-lines. Although the parents may not always know the exact time that the deployment will take place, it is still helpful to make an estimate, and then help a child craft a calendar of some type, illustrated and punctuated with events which help to define time for them. Examples to include are

holidays, birthdays, special family and extended family events, school events, vacations, and other “markers” which help to divide up the time of deployment absence into short and finite time episodes. Create a paper timeline with dates, which extends around a room, which can be illustrated by the child, or make a chain made of illustrated paper links, which are dated and illustrated. These links can be cut ceremoniously on a daily basis.

6. To children, no news is worse than bad news. Studies with children of deployed parents reveal that the children’s main preoccupation from day to day is not over the absent parent, but with the remaining parent. At some level, children are concerned about what is going on with the remaining parent. If that parent becomes short, cross, self-absorbed, tearful, with no explanation, the child’s fantasies about that parent’s ability to function are worse than what the reality is. Thus, the remaining parent should be relatively open about sharing concerns and news about the deployed parent. If the child has an explanation as to why the parent is irritable, tearful, or preoccupied, it is much easier to accept. Parents should not use their children as surrogate adults and load all of their concerns on the child, but should use judgement in sharing enough to ease the child’s worries.

7. Listen to a child’s worries about the deployed parent and answer questions as truthfully as possible. Follow up a child’s questions with further questions as to what prompted them to bring up an issue. Listen carefully first, before trying to dispel what you consider to be false notions on the part of the child. Explore as far as possible a child’s question and concern to show that you are trying to understand what he/she is worried about. Don’t keep pursuing the issue after a child appears to be

satisfied. Be reassuring about protective measures and training designed to protect the deployed parent, but do not make false assurances about not getting hurt or not dying.

8. Maintain firm routine and discipline in the home. Under the best of circumstances, maintaining order and routine for children in the home is difficult. It is even more difficult when a parent is suddenly absent. The child will manifest anxiety about this new separation, and the concerns over the ability of the remaining parent to function, by testing the resolve of the remaining parent, testing rules, and flouting routines. With the increase in responsibilities, numbers of tasks and new stresses, it will be tempting not to pursue and enforce limits. Only later does it become evident that the stress level increases quickly, when it is too late. Be proactive and discuss with the child your intent to have very firm routines related to bedtimes, morning routines, room clean-up, chore accountability, and homework. Then follow through with a clear and predictable set of consequences and rewards to keep the program going.

9. Initiate and maintain a close relationship with the school and the child’s teacher. Have a conference with the significant figures in the child’s schooling, depending on the child’s level. This may only involve the child’s classroom teacher for the young child, or others, such as several teachers, counselor, or principal for the older child or special needs child. Make clear to them that the child’s parent has been deployed and that there may be an increase in stress at home. Anticipate the first signs of stress in the child. Signs of vulnerability and stress are deteriorating academic performance, behavioral problems in the classroom, problems in peer relationships, unexplained

mood changes, tearfulness or irritability, or worsening of previously existing behavioral problems. Have a plan devised with the school authorities for constructive and helpful interventions to support the child and redirect him/her to previous levels of successful function. Be ready to have further conferences if necessary. Be proactive and take the lead.

10. As the remaining parent, make sure you take care of yourself. If one is interested in the wellbeing of a child, the dictum is always, “Take care of the caretaker.” Unfortunately, because of the many demands upon the remaining parent, it is difficult to make this happen. Taking care of oneself must be seen as a necessity and given high priority in planning. Frequently, the remaining parent is basically a working single parent. However, sit and plan a schedule, and include the child in the planning if it is appropriate. Let your child know that you will be much better able to take care of him/her, that you will be much more fun to be with, and have more energy if you can take time to get out and exercise, take a scheduled nap, have alone time, or take time with a good supportive friend. The time periods can be short, but should be planned, so that you are not feeling guilty. Express appreciation to your child when you take the time for yourself, and let him/her know how much better you feel.

Revised 4 February 2003
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Medicine
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